

Late Posttraumatic Tricuspid Valve Insufficiency Repaired By Artificial Cordae

Eurasian Clinical and Analytical Medicine Case Report

Posttraumatic Tricuspid Insufficiency Repaired By Artificial Cordae

Kemal Korkmaz, Serhat Bahadır Genç, Ali Baran Budak, Hikmet Selçuk Gedik, Kerim Çağlı
Clinic of Cardiovascular Surgery, Ankara Numune Training and Research Hospital, Ankara, Turkey

Abstract

We report the case of a 45-year-old female who was referred to our clinic with dyspnea and palpitation. We learned from patient history that she had sustained a car accident 15 years ago. Transthoracic echocardiography revealed rupture of anterior tricuspid leaflet and prolapse of mitral valve causing severe tricuspid and moderate mitral valve regurgitation. Mitral valve was repaired with artificial cordae replacement and ring annuloplasty. Tricuspid valve was also repaired with anterior tricuspid leaflet triangular plication and ring annuloplasty after artificial cordae implantation. Longitudinal right atrial incision was sutured vertically and right atrium size was reduced with plication. First and sixth month echocardiographic follow up's showed trivial tricuspid insufficiency without any complaints.

Keywords

Posttraumatic Tricuspid Valve Insufficiency; Mitral Valve Regurgitation; Artificial Chordae; Ring Annuloplasty

DOI:10.4328/ECAM.36

Received : 13.09.2014

Accepted : 17.09.2014

Published Online : 19.09.2014

Printed Online : 19.09.2014

Eu Clin Anal Med 2014;2(3): 23-5

Corresponding Author: Kemal Korkmaz, Ankara Numune Eğitim ve Araştırma Hastanesi, Kalp ve Damar Cerrahisi Kliniği, 06100, Altındağ, Ankara, Türkiye.

GSM: +90 505 572 61 11 • **P:** +90 312 508 42 85 • **F:** +90 312 311 43 40 • **E-Mail:** kemalkorkmaz44@hotmail.com

How to cite this article: Kemal Korkmaz, Serhat Genc, Ali Baran Budak, Hikmet Selcuk Gedik, Kerim Caglı. Late posttraumatic tricuspid valve insufficiency repaired by artificial cordae. Eu Clin Anal Med 2014;2(3): 23-5.

Introduction

Posttraumatic tricuspid insufficiency (TI) due to rupture of the chordal structure of the tricuspid valve (TV) is a very rare entity and mostly caused by blunt chest trauma. Clinical symptoms are generally mild and the hemodynamic consequences are often well-tolerated, so most of the cases has been diagnosed and treated several years after initial trauma [1].

Posttraumatic TI can be caused by several reasons such as annular detachment of leaflets, anterior leaflet cordae rupture and papillary muscle rupture [2-4].

Here we present the surgical repair of tricuspid and mitral valve regurgitation which was caused by blunt chest trauma 15 years ago.

Case Report

A 45-year-old female patient was referred to our hospital with complaints of progressive dyspnea and palpitation. She did not have any reported medical problem; however we learned that she had suffered from blunt chest trauma 15 years ago because of a car accident. A detailed physical examination revealed a grade 3-4/6 pansystolic murmur along the left lateral sternal border. Chest X-ray revealed an enlarged cardiac silhouette. Transthoracic echocardiography (TTE) showed severe (4+) TI with severe right ventricular dilatation, right atrial dilatation (8.9x9.0 cm), rupture of the chordae of the anterior tricuspid valve leaflet and moderate (2+) mitral insufficiency due to mitral valve prolapse. Right ventricular ejection fraction was 56%.

Further investigations with cardiac catheterization and coronary angiography revealed normal coronary arteries. Magnetic resonance imaging (MRI) was planned to patient and MRI confirmed right ventricular dilatation with major axis 8.9 cm and minor axis 5.5 cm. On the basis of these findings medical treatment was established with b-blockers and diuretics and surgery was planned. (Figure 1)

Operation

A standard midline sternotomy incision was performed. After pericardiotomy, a giant right atrium was observed. After full systemic heparinization, cardiopulmonary bypass was established by aortic and bicaval cannulation. Myocardial protection was provided by antegrade/retrograde cold crystalloid cardioplegia, topical cooling and moderate systemic hypothermia.

Right atrium was opened with horizontal incision. Mitral valve was

evaluated via atrial septum (transeptal approach) and anterior mitral valve prolapse was observed. Prolapse of the anterior leaflet of the mitral valve was repaired with artificial chordal replacement. The loop technique which uses the Hegar dilator to prepare loops of artificial neo-chorda was previously described [5].

Mitral valve repair was completed by the application of a flexible mitral ring and the iatrogenic atrial septal defect was primarily sutured. Saline injection test was made to control the coaptation.

After completion of mitral valve repair, tricuspid valve was examined. There was flail anterior tricuspid leaflet due to ruptured chordae (Figure 2, a). Furthermore secondary chordae was tethering and restraining the motion of the anterior leaflet.

Tethering secondary chordae were cut to improve the motion of the anterior leaflet.

The same artificial chordal loop technique was used for the corrective repair which was completed by flexible ring annuloplasty. (Figure 2 b,c,d)). Triangular resection and plication was performed (Figure 2, e (triangular area)). Saline injection test was made to control the coaptation (Figure 2, f).

After completion of the mitral and tricuspid valve repair, horizontal right atrial incision was plicated vertically (Figure 2 g). A two-chambered atrium, consisting of caval part and functional right atrium, was created to reduce the size (Figure 2 h)). Following declamping, normal sinus rhythm was obtained and decannulation was performed without any hemodynamic problem.

Postoperative period was uneventful and the patient was discharged at the postoperative 7th day. Follow-up transthoracic echocardiographic studies, which were performed at 1st and 6th month postoperatively, revealed normally functioning valves (Movie 1).

Discussion

Blunt chest-wall trauma is common during traffic accidents. Traumatic cardiac injuries include myocardial contusion, pericardial effusion, injuries of great vessels or coronary arteries and valvular disruptions. Among valvular injuries, aortic valve is the most frequently affected valve [2, 6, 7].

A sudden antero-posterior compression generates a severe tension and a regurgitant jet that can result in the rupture of papillary muscle and/or chordae tendinae, especially during the end-diastolic phase. Furthermore, valvular disruption can occur over time because of inflammation, necrosis or contusion of the papillary muscles or chordae

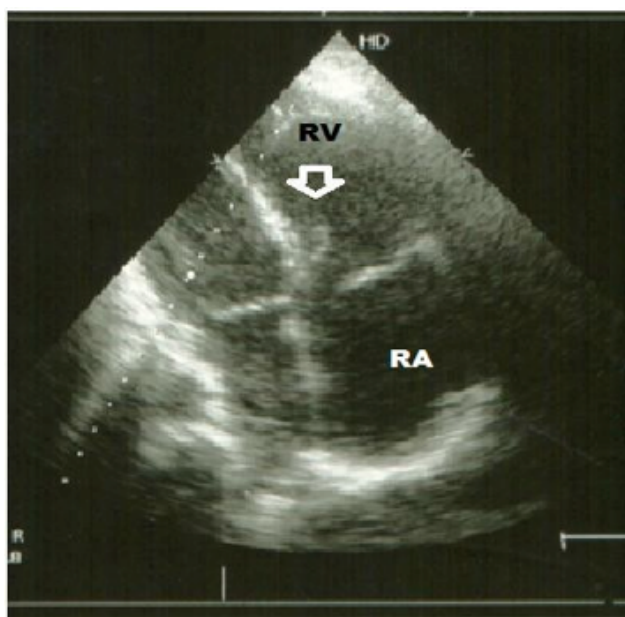


Figure 1. Tricuspid valve, Flail anterior leaflet (arrow). [RA right atrium, RV right ventricle]

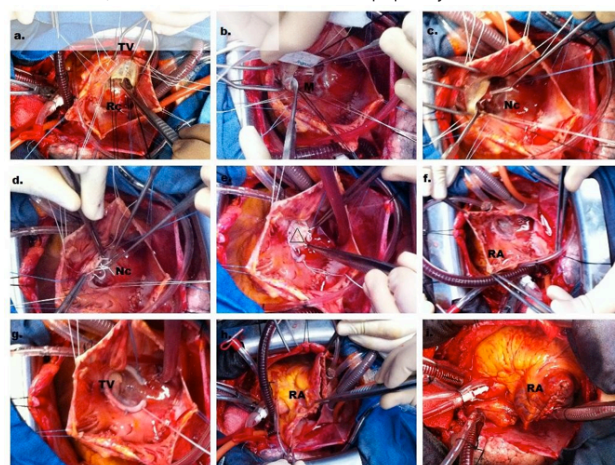


Figure 2. Tricuspid valve repair; [a: Ruptured chordae (Rc), b: Edge to moderator band (M) measure of neo-chordae, c: Implantation of neo-chordae loops stem to moderator band (M), d: Neo-chordae attachments to TV edges, e: Triangular plication of prolapsed tricuspid valve (TV), f: Right atrial (RA) view after valvuloplasty, g: Coaptation test, h: Right atrial closure technique, i: New double chambered right atrium.]

Movie 1. Tricuspid Valve, Postoperative Doppler Echocardiography

tendineae [1, 8].

There an ongoing debate in the use of echocardiography as a screening tool in patients who are suffering from blunt chest wall trauma. Furthermore, both TTE and transeosaphagial echocardiography(TEE) have their limitations, though the diagnostic value of TEE is 56% and upon TTE, the yield is lower [7].

We suggest repeat examinations or the application of other imaging methods if clinical suspicion exists.

Traumatic TI is a very rare condition but the true frequency of this disease is probably underestimated because of a possible long asymptomatic phase [9, 10]. Patients become symptomatic following dilatation of right cardiac chambers and the annular dilatation. Mitral valve involvement contributes the progressive dilatation resulting in right ventricular failure.

Functional TI is more amenable for repair to preserve the right ventricular function. Right atrial dilatation over 8 cm and right ventricular dilatation over 5,5 cm is a challenging situation. However, tricuspid valve repair is superior with lower mortality and freedom from reoperation rates [11, 12].

Precise measurement of artificial cordae length and adequate plication of the leaflet without reducing the valve area and increasing the coaptation zone were the key pitfalls in this successful repair. Short term results shows this method can be used even delayed cases of posttraumatic TI with ventricular and atrial dilatation.

Scientific Responsibility Statement

The authors declare that they are responsible for the article's scientific content including study design, data collection, analysis and interpretation, writing, some of the main line, or all of the preparation and scientific review of the contents and approval of the final version of the article.

Animal and human rights statement

All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. No animal or human studies were carried out by the authors for this article.

Funding: None

Conflict of interest

None of the authors received any type of financial support that could be considered potential conflict of interest regarding the manuscript or its submission.

References

1. Bortolotti U, Sciotti G, Milano A, Guglielmi C, Benedetti M, Tartarini G, et al. Post-traumatic tricuspid valve insufficiency. 2 cases of delayed clinical manifestation. *Tex Heart Inst J* 1997;24(3):223-5.
2. Correia PM, Coutinho GF, Antunes MJ. Severe Tricuspid regurgitation after traumatic papillary muscle rupture. *Eur J Cardiothorac Surg* 2012;41(5):128. doi: 10.1093/ejcts/ezs095.
3. Lin SJ, Chen CW, Chou CJ, Liu KT, Su HM, Lin TH, et al. Traumatic tricuspid insufficiency with chordae tendinae rupture: a case report and literature review. *Kaohsiung J Med Sci* 2006;22(12):626-9.
4. Mehrotra D, Dalley P, Mahon B. Tricuspid valve avulsion after blunt chest trauma. *Tex Heart Inst J* 2012;39(5):668-70.
5. Cagli K. A simple method of making artificial chordal loops for mitral valve repair. *Ann Thorac Surg* 2010; doi: 10.1016/j.athoracsur.2009.11.055
6. Bernabeu E, Mestres CA, Lama-Orsorio P, Josa M. Acute aortic and mitral valve regurgitation following blunt chest trauma. *Interact Cardiovasc Thorac Surg* 2004;3(1):198-200.
7. Ismailov RM, Weiss HB, Ness RB, Lawrence BA, Miller TR. Blunt cardiac injury associated with cardiac valve insufficiency: trauma links to chronic disease? *Injury* 2005;36(9):1022-8.
8. Kulik A, Al-Saigh M, Yelle JD, Rubens FD. Subacute tricuspid valve rupture after traumatic cardiac and pulmonary contusions. *Ann Thorac Surg* 2006;81(3):1111-2.
9. Emmert MY, Pretre R, Suendermann S, Weber B, Bettex DA, Hoerstrup SP, et al. Severe traumatic tricuspid insufficiency detected 10 years after blunt chest trauma. *Clin Res Cardiol* 2011;100(2):177-9.
10. Furukawa N, Hakim-Meibodi K, Gummert J. Isolated latent tricuspid regurgitation caused by blunt trauma. *Thorac Cardiovasc Surg* 2011;59(8):497-9.
11. Said SM, Burkhart HM, Schaff HV, Johnson JN, Connolly HM, Dearani JA. When should a mechanical tricuspid valve replacement be considered? *J Thorac Cardiovasc Surg* 2014;148(2):603-8.
12. Mestres CA, Fita G, Parra VM, Pomar JL, Bernal JM. Tricuspid valve surgery. *HSR Proc Intensive Care Cardiovasc Anesth* 2012;4(4):261-7.